3sHealth – Employee Benefits
600-1919 Saskatchewan Drive Regina, SK S4P 4H2
T. 306-347-5519 F. 306-347-5910
Toll Free: 1-866-278-2301
Email: ebp@3sHealth.ca

Employee's Initial Application Disability Income Plan Benefits

TO BE COMPLETED BY EMPLOYEE

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#
Address	City	Province	Postal Code
Telephone - Home	Cel	Email Address	

CLAIM INFORMATION

What is your medical condition that is/was preventing you from working?

During your absence, have you performed any other work? ❑ No ❑ Yes, describe:

When do you expect to return to work? dd/mm/yy

Is your condition work related? ❑ No ❑ Yes, provide the date you sent your application to WCB dd/mm/yy

Is your condition due to the result of a motor vehicle accident? ❑ No ❑ Yes, provide the date you sent your application to SGI dd/mm/yy

Is your condition due to the result of another type of accident? ❑ No ❑ Yes, provide details about your accident

Please provide the names of the physician(s) or nurse practioner treating you for your medical condition.

Name of Physician/Nurse Practioner	Specialty	Date last visited dd/mm/yy

OTHER INCOME

Have you received income from any of the sources listed below during your absence from work? ❑ No ❑ Yes

If yes, please check the appropriate box and note that you must provide with this form a copy of correspondence that states the type of income or benefit you received, the amount you received, and the date you recieved the income or benefit, if you have not already submitted this information to 3sHealth.

❑ Canada Pension Plan (CPP) (disability and/or retirement)
❑ Other Income (please specify)
❑ Private Insurance
❑ WCB
❑ Employment Insurance
❑ SGI

Is legal action pending against a third party? ❑ No ❑ Yes, provide the name of your lawyer

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth dd/mm/yy	Benefit ID#

INCOME DECLARATION AND REIMBURSEMENT AGREEMENT

Under your Disability Income Plan (the Plan), you are required to apply for disability benefits that you or your family members may be entitled to under other disability programs, such as workers' compensation or Canada Pension Plan benefits (Other Disability Benefits).

Other Disability Benefits and any other income you receive (Reportable Income) while on an approved disability leave offset and reduce the disability benefit payments you are entitled to receive under the Plan, which can result in an overpayment from the Plan. These overpayments must be repaid to 3sHealth Employee Benefits (3sHealth), as the Plan administrator.

In accordance with the terms of the Plan, your disability benefit payments are conditional on the following terms and conditions:

1. You will promptly apply for any Other Disability Benefits for which you or your family members are eligible to apply. 3sHealth, as Plan Administrator, may require you to reapply or appeal decisions refusing your application(s) for Other Disability Benefits.
2. You will notify 3sHealth within 15 days of receiving any Other Disability Benefits or Reportable Income and disclose the amount of any such payment.
3. Upon receiving your notice, 3sHealth will determine whether the receipt of the Other Disability Benefits or Reportable Income resulted in an overpayment to you under the Plan and, if so, notify you of the amount of the overpayment (Overpayment Amount) and a schedule for repayment.
4. You must repay the Overpayment Amount to 3sHealth within the time frame established by 3sHealth in its sole discretion.
5. Failure to repay the Overpayment Amount or to report the receipt of Other Disability Benefits or Reportable Income constitutes a debt owing to 3sHealth, as administrator of the Plan, for the Overpayment Amount.

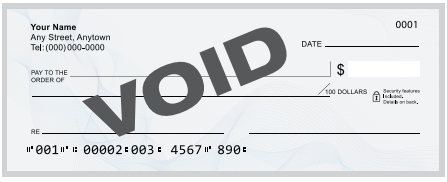
3sHealth will take all necessary steps to recover the Overpayment Amount, including withholding from benefits payable under the Plan or commencing legal proceedings.

Your signature below acknowledges that you agree to the above terms and conditions.

DIRECT DEPOSIT INFORMATION

Please provide the information for the bank account you wish your disability benefit payments to be deposited to. Please attach a void personal cheque or an encoded deposit slip for your bank account.

PLEASE ATTACH A PERSONAL CHEQUE MARKED "VOID" OR AN ENCODED BANK DEPOSIT SLIP



CERTIFICATION, STATEMENT OF ACCEPTANCE AND AUTHORIZATION

I hereby certify that the answers are full and true to the best of my knowledge and belief, and I am aware that any intentional misrepresentation of facts could result in the immediate termination of benefits. I authorize any government agency including the Workers' Compensation Board, Health Canada and Saskatchewan Government Insurance to furnish to Health Shared Services Saskatchewan – 3sHealth any information required in connection with this claim, and request that any physician or health care practitioner provide 3sHealth with any information requested in connection with this claim. A photocopy of this authorization shall be valid.

I acknowledge and understand that all of my personal information collected by 3sHealth, including the personal information contained in this application form and any personal information disclosed by my employer, physicians or other medical practitioners which is required by 3sHealth in support of this application form is being collected by 3sHealth for the purpose of administering the 3sHealth Plan, and to meet 3sHealth's obligations under applicable law, and I hereby authorize and consent to the collection, use and disclosure of my personal information including my Social Insurance Number by 3sHealth for such purposes. I acknowledge and agree that my consent to the foregoing is a fundamental condition of 3sHealth providing administration and other services to myself in connection with the 3sHealth Plan, and that my consent may not be revoked or withdrawn without limiting or terminating those services.

I have read, understood and accept the terms and conditions of my disability benefit payments under the Plan. I acknowledge that any Overpayment Amounts constitute a debt owing by me to 3sHealth, as administrator of the Plan.

Note: Disability benefits are only paid by direct deposit to your bank or other financial institution. Please be sure to attach a completed Payroll Data Form (form number DIP 15) along with a void cheque or encoded deposit slip.

Note: Your failure to fully complete this form may result in our returning the form to you and in a delay in our evaluation of your application.

Plan member signature:	Date Signed: dd/mm/yy